

GEORGIA CHILD FATALITY REVIEW PANEL

**Annual Report
Calendar Year 2003**



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Each year, the staff of the Georgia Child Fatality Review Panel (Panel) assesses both the progress of child fatality review (cfr) in each of the 159 local counties, and the influence of cfr at the State level. This information assists us in determining the impact of our current efforts, and charting our course for the future. When examining the work of local cfr committees, four key elements are measured: member participation, percentage of eligible deaths reviewed, thoroughness/accuracy of reports, and advocacy for prevention. Annually, we have seen improvement in each of these areas:

- 1) There are eight disciplines mandated by law or policy to have member participation on cfr committees. The 586 child fatalities reviewed in 2003 had approximately 75% of all members present at each review.
- 2) The percent of eligible deaths reviewed continues to increase, with no exception for 2003. Counties reviewed 556 of 586 eligible deaths representing a 95% compliance rate
- 3) The number of reports received requiring additional or amended information decreased, indicating counties have a better understanding of information needed, and are more diligent in obtaining it
- 4) An increase in the number of counties making, and advocating for prevention recommendations within their counties and to the State, demonstrates a fundamental shift in thinking regarding the purpose and potential of cfr

When evaluating cfr influence at the State level, our focus has been primarily in three (3) areas: regulatory recommendations, legislative recommendations, and education. A number of regulatory and legislative recommendations were made in the Panel's Annual Report for 2002 child deaths.

The results of those acted upon included:

DFCS

- Initial efforts to strengthen the child protective services risk assessment and safety tools

Coroners

- An increase in the number of death scene investigations conducted for suspicious, unexpected, and unexplained child deaths

Legislation

- The Child Protection Bill, which was supported by the Panel
- A broader child restraint law for children under the age of 7, which was supported by the Panel

Education

- Extensive efforts by Panel staff to educate human service professionals, government officials, legislators, law enforcement, and child advocates on both the prevalence of child deaths, and opportunities for prevention. Various channels of communication were employed

Our assessment of this past year revealed that progress has been made at both the county and state levels. This systematic progress positions us to proceed to the next step – a statewide, injury prevention plan. A plan for children neglected and abused; a plan for children dying from injuries sustained unintentionally; a plan for children whose lives are lost at the hands of another; a plan for children whose lives seem so miserable that death is a welcomed relief.

One lesson learned is that collaboration and teamwork at local and state levels are necessities if success is to be realized. Therefore, this plan must be crafted by all of us whose mission is the safety and protection of children. We must see our work in promoting the well being of children as a continuum of care, and not operate with tunnel vision. It really does take a village to raise a child.

EXECUTIVE SUMMARY

The Georgia Child Fatality Review Panel (Panel) publishes an annual report chronicling the tragic, preventable deaths of children in Georgia. Information in this report details deaths that were sudden, unexplained and/or unexpected. This information is compiled from reports submitted by local child fatality review committees. The Panel is charged with tracking the numbers and causes of child deaths as well as identifying and recommending prevention strategies that could reduce the number of child deaths.

Key Findings

In 2003, 1,794 children died in Georgia. Based on death certificate data, 586 deaths were eligible for review. Child fatality review committees reviewed 556 (95%) of those deaths and an additional 119 deaths; however, the cause of death listed on death certificates and the cause of death determined by child fatality review committees sometimes differed.

FATAL CHILD ABUSE/NEGLECT

Department of Family and Children Services reported that 70 children in Georgia died as a result of substantiated abuse or neglect. Those deaths were investigated by DFCS, and did not include deaths handled by law enforcement and the courts without DFCS involvement.

Child fatality review committees determined that 82 child deaths resulted from confirmed abuse/neglect, and 79 child deaths resulted from suspected abuse/neglect. Perpetrators were identified in 118 of the 161 abuse/neglect related deaths, as well as the relationship of the perpetrator to the child. Fifty-two percent (52%) of those perpetrators were natural parents. Homicide was the cause of 42 confirmed abuse deaths, and children under the age of 5 accounted for 79% (33) of those homicides.

NATURAL

Death certificate data indicated a total of 1326 children under the age of 18 died of natural causes (including SIDS). Infants accounted for the vast majority (1,074) of those deaths. The leading causes of infant deaths continued to be congenital anomalies, low birth weight, and prematurity. There were 103 SIDS deaths, which was a 27% decrease from the previous year.

Child fatality review committees reviewed 234 deaths from natural causes. One hundred twenty-one (121) of those deaths were SIDS/SUID. (SUID –

Sudden Unexplained Infant Death - is a term used for a death that appears to be SIDS, but has other factors that *could* have contributed to the death.) Committees are required to review all SIDS/SUID deaths, and medical deaths that are unexpected or unattended by a physician.

INJURIES

Death certificate data listed 441 deaths to have resulted from known injuries, but 6 of those deaths listed an unknown intent. An additional 27 deaths listed an unknown cause.

UNINTENTIONAL INJURIES

Death certificate data indicated that 59% (383) of deaths in children ages 1 – 17 resulted from injuries (infant deaths [1150], were mostly due to natural causes [1074]). Seventy-seven percent (77%) of all injuries in the 1 – 17 year age group resulting in death were unintentional (excludes unknown intent and unknown cause). The 3 leading causes of unintentional injury-related deaths in all age groups were:

- 211 motor vehicle incidents
- 37 drowning incidents
- 25 fire/burn related incidents

There was a slight increase in the number of all deaths caused by unintentional injuries (from 324 to 336) over the previous year. The most marked increase in unintentional deaths from 2002 was suffocation (19 in 2002 to 35 in 2003).

Child fatality review committees reviewed 334 deaths attributed to unintentional injuries. Child fatality review and death certificate data agreed on the 3 leading causes of death related to unintentional injuries (see above). Committees also identified a marked increase in the number of deaths due to suffocation (21 in 2002 to 40 in 2003).

INTENTIONAL INJURIES

Death certificate data indicated 99 children died from injuries intentionally inflicted by themselves or by others (homicides and suicides). In 2003, there were 71 homicides (a 22% increase from 2002), and 28 suicides (a 12% increase).

Child fatality review committees reviewed 101 deaths from intentional causes – 71 homicides and 30 suicides. Committees determined additional deaths to have resulted from suicide that were not identified as such on death certificates.

FIREARM DEATHS

Death certificate data indicated firearms were used in 43 child deaths. Thirty-two (32) of those deaths were ruled homicides, and 11 were ruled suicides.

Child fatality review committees reviewed 43 firearm related deaths. Eighty-six percent (86%) were intentional (26 homicides and 11 suicides). The type of firearm was identified in 39 of the 43 reviewed firearm related deaths. Handguns were most frequently used (31 of the 39 deaths where type of firearm was identified).

UNKNOWN DEATHS

Death certificate data identified 27 infant/child deaths with an “Unknown” cause of death. CFR committees reviewed 24 of those 27 deaths and assigned an “Unknown” cause to only one of the 24. They determined the 23 deaths to be SIDS (3), SUID (9), medical cause (5), and 6 were other violent causes.

Child fatality review committees identified 4 deaths for which they were unable to determine a cause of death. One of those deaths (referenced in preceding paragraph) also had “Unknown” ICD10 code on the death certificate. The death certificate assigned causes for the remaining 3 deaths as medical, SIDS, and poison.

PREVENTABILITY

A primary function of the child fatality review process is to identify those deaths believed to be preventable. The issue of preventability was addressed in all 675 child deaths reviewed. Child fatality review committees determined that 79% (533) of the 675 reviewed child deaths were definitely or possibly preventable. Ninety-six percent (96%) of all reviewed child abuse/neglect related deaths were determined to be definitely or possibly preventable.

AGENCY

INVOLVEMENT/INTERVENTION

Child fatality review committees reported that in 108 (67%) of the 161 child abuse/neglect related deaths, the child and/or family had prior involvement with at least one state or local agency. Committees identified 8 deaths for which they concluded an agency intervention could have prevented the death. Four (4) of those 8 deaths had an abuse/neglect finding.



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